TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
TEXAS SURGICAL CENTER

**Respondent Name**
LIBERTY INSURANCE CORP

**MFDR Tracking Number**
M4-17-1081-01

**Carrier's Austin Representative**
Box Number 01

**MFDR Date Received**
DECEMBER 16, 2016

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "**The attached claim was not paid according to the 2016 Texas Ambulatory Surgical Center Fee Schedule**."

**Amount in Dispute:** $755.37

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The procedure code billed is 27626 LT 52. Code 27626LT is for Left Ankle Arthrotomy. The -52 modifier indicated a reduced or discontinued service. The provider's explanation for the request for additional reimbursement does not address the -52 modifier but it remains on the bill after two requests for reconsideration. As billed, we cannot determine the additional reimbursement is required. The provider is indicting that fee schedule reimbursement for this code is $3021.47. The 52 modifier would allow for a 25% reduction. $3021.47 X 75% = $2266.10 = the amount already reimbursed."

Response Submitted By: Liberty Mutual Insurance

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| July 25, 2016 | Ambulatory Surgical Care Services<br>CPT Code 27626-LT-52 | $755.37 | $755.34 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective

August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
    - P300-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
    - B13, W3, 193-The charge for this procedure exceeds the fee schedule allowance.
    - X598-Claim has been re-evaluated based on additional documentation submitted; no additional payment due.

**Issues**

1. Is the requestor entitled to additional reimbursement for CPT code 27626-LT-52 rendered on July 25, 2016?

**Findings**

1. The requestor is seeking additional reimbursement of $755.37 for ambulatory surgical care services , rendered on July 25, 2016.

   The fee guideline for Ambulatory Surgical Care services is found in 28 Texas Administrative Code §134.402.

   28 Texas Administrative Code §134.402(d) states,

   > For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section.

   CPT code 27626 is defined as "Arthrotomy, with synovectomy, ankle; including tenosynovectomy."

   28 Texas Administrative Code §134.402(f)(1)(A) states,

   > The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the *Federal Register*. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply: (1) Reimbursement for non-device intensive procedures shall be: (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent.

   According to Addendum AA, CPT code 27626 is a non-device intensive procedure. The requestor appended modifiers "LT-Left Side" and "52-Reduced Services" to code 27626.

   Per CMS Manual System, Publication 100-04, Medicare Claims Processing, Transmittal 442, Change Request 3507, effective January 21, 2005:

   > **I. SUMMARY OF CHANGES:** This manual revision clarifies use of modifiers -52, -73, and -74. These modifiers are used to report procedures that are discontinued by the physician due to unforeseen circumstances. Modifier -52 is used to indicate partial reduction or discontinuation of radiology procedures and other services that do not require anesthesia. For surgeries and certain diagnostic procedures requiring anesthesia (including colonoscopies), the hospital may receive 50 percent of the OPPS payment amount for cases in which the procedure is discontinued after the beneficiary was prepared for the procedure and taken to the room where the procedure was to be performed. If the procedure is discontinued after the beneficiary has received anesthesia or after the procedure was started (e.g., scope inserted, intubation started,

incision made) the hospital may receive the full OPPS payment amount for the discontinued procedure. For purposes of billing for services furnished in the hospital outpatient department, anesthesia is defined to include local, regional block(s), moderate sedation/analgesia ("conscious sedation"), deep sedation/analgesia, and general anesthesia.

A review of the submitted medical records finds that the claimant underwent the ankle procedure under general anesthesia; therefore, per Publication 100-04, the requestor is due the full MAR reimbursement.

The Medicare fully implemented ASC reimbursement for code 27626 CY 2016 is $1,339.58.

**To determine the geographically adjusted Medicare ASC reimbursement for code 27626**:

The Medicare fully implemented ASC reimbursement rate of $1,339.58 is divided by 2 = $669.79.

This number multiplied by the City Wage Index Midland, Texas is $669.79 X 0.9196 = $615.93.

Add these two together $669.79 + $615.93 = $1,285.72.

**To determine the MAR multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235%**

$1,285.72 X 235% = $3,021.44. The respondent paid $2,266.10. The difference between the MAR and amount paid is $755.34; therefore, additional reimbursement is recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $755.34.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $755.34 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | 01/12/2017<br>Date |
|---|---|---|

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.